CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PAYMENT

9505.5000 APPLICABILITY.

Parts 9505.5000 to 9505.5105 establish the procedures for prior authorization of health services and the requirement of a second surgical opinion as conditions of payment to providers of health services for recipients of medical assistance, MinnesotaCare, and general assistance medical care.

These parts shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, sections 430.00 to 489.57; Minnesota Statutes, sections 256.9353; 256B.01 to 256B.40; 256B.56 to 256B.71; 256D.01 to 256D.22; parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9505.0170 to 9505.0475; 9505.0500 to 9505.0540; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256.9352, 256.991, and 256D.03, subdivision 7, paragraph (b).

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by:

A. the department, or an entity under contract to the department, to issue a number to a provider for the provision of a covered health service, as specified in part 9505.5010; or

B. the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify criteria for the approval of authorization requests in his or her area of expertise; advises the department on and recommends to the department policies concerning health services and whether health services meet the criteria in part 9505.5045; and performs other duties as assigned.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Emergency.** "Emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 6. **Fair hearing.** "Fair hearing" means an administrative proceeding under Minnesota Statutes, section 256.045 and as provided in part 9505.5105, to examine facts concerning the matter in dispute and to advise the commissioner whether the department's decision to reduce or deny benefits was correct.

Subp. 7. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, chapter 256D.

Subp. 8. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider as defined in subpart 16.

Subp. 9. **Investigative.** "Investigative" means:

A. A health service procedure which has progressed to limited human application and trial, which lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and utilized by Blue Cross and Blue Shield of Minnesota in the administration of their program.

B. A drug or device that the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices shall be those identified in the Food and Drug Act.

Subp. 10. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the medical assistance and general assistance medical care programs.

Subp. 11. **Local trade area.** "Local trade area" means the geographic area surrounding the recipient's residence which is commonly used by other persons in the same area to obtain necessary goods and services.

Subp. 12. **Medical assistance or MA.** "Medical assistance" or "MA" means the Medicaid program established by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 12a. **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a second or third surgical opinion has substantiated the need for the procedure.

Subp. 12b. **Medical review agent.** "Medical review agent" means the representative of the department who is authorized in parts 9505.0500 to 9505.0540 to determine the medical appropriateness of procedures requiring second surgical opinions.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

Subp. 13a. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, sections 256.9351 to 256.9361.

Subp. 14. **Physician.** "Physician" means a person licensed to provide services within the scope of his or her profession as defined in Minnesota Statutes, chapter 147. For purposes of the second surgical opinion requirement in parts 9505.5035 to 9505.5100, "physician" shall also mean:

A. a person licensed to provide dental services within the scope of his or her profession as defined in Minnesota Statutes, section 150A.06, subdivision 1; or

B. a person who is qualified to render an opinion regarding the surgical procedure as evidenced by his or her certification or eligibility for certification from the appropriate specialty board if, according to the community standard, such certification or eligibility for certification is required of persons performing the surgical procedure in question.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department, or by an entity under contract to the department, to a provider for the provision of a covered health service, as specified in part 9505.5010, prior to payment for that service.

Subp. 16. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

Subp. 18a. **Second opinion or second surgical opinion.** "Second opinion" or "second surgical opinion" means the determination by the medical review agent under part 9505.5050, subpart 1, or by a second physician under part 9505.5050, subpart 2, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 18b. **Third opinion or third surgical opinion.** "Third opinion" or "third surgical opinion" means the determination by a third physician under part 9505.5050, subpart 3, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** A provider shall obtain prior authorization as a condition of payment under the medical assistance, general assistance medical care, and MinnesotaCare programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. The provider of the health service shall submit the request on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form as required in subpart 3, and shall submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient. If the provider obtains prior authorization before the health service is provided but before payment, the provider shall be assured payment at the authorized level after the recipient has received the service. If a provider requests prior authorization after the service has been provided but before payment, the provider shall be assured of payment only if prior authorization is given. Additionally, prior authorization shall assure the provider payment for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 2. **Repealed, 19 SR 2433**

Subp. 3. **Submission of forms.** The provider shall submit to the department a request for prior authorization on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form, which has been completed according to instructions in the Minnesota Health Care Programs Provider Manual, and other information necessary to address the criteria in part 9505.5030. The provider shall bear the burden of establishing compliance with the criteria in part 9505.5030 and shall submit information which demonstrates that the criteria in part 9505.5030 are met. The provider who administers or supervises the recipient's care shall personally review and sign the form and any attached documentation.

Subp. 4. **Consequences of failure to comply.** A provider who furnishes health services without obtaining prior authorization under parts 9505.5010 to 9505.5030 shall be denied payment. A physician, hospital, or other provider who is denied payment because of failure to comply with parts 9505.5010 to 9505.5030 shall not seek payment from the recipient and the recipient shall not be liable for payment of the service for which the provider is denied payment due to lack of prior authorization.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 16 SR 2102; 19 SR 2433

9505.5015 Repealed, 19 SR 2433

9505.5020 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Notification requirements.** If the information submitted by the provider does not meet the requirements of part 9505.5030, the department shall notify the provider of what is necessary to complete the request. The department shall send the provider, within 30 working days of receipt of all the information required in part 9505.5010, a notice of the action taken on the request for prior authorization. If the prior authorization request is denied, the department shall send the recipient within the same time period a copy of the notice sent to the provider and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **Retention of information submitted by provider.** The department shall have the right to retain information submitted to the department by the provider in accordance with part 9505.5010.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5025 HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization for health services to be provided outside of Minnesota under part 9505.0215 must be obtained before the service is provided. A health service that is provided to a Minnesota resident outside of Minnesota but within the recipient's local trade area and that would not require prior authorization if it were provided to a Minnesota resident within Minnesota shall be exempt from the prior authorization requirement.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5030 CRITERIA FOR APPROVAL OF PRIOR AUTHORIZATION REQUEST.

A request for prior authorization of a health service shall be evaluated by consultants using the criteria given in items A to F. A health service meeting the criteria in this part shall be approved, if the health service is otherwise a covered service under the MA or GAMC programs. The health service must:

A. be medically necessary as determined by prevailing medical community standards or customary practice and usage;

B. be appropriate and effective to the medical needs of the recipient;

C. be timely, considering the nature and present state of the recipient's medical condition;

D. be furnished by a provider with appropriate credentials;

E. be the least expensive appropriate alternative health service available; and

F. represent an effective and appropriate use of program funds.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION.

Subpart 1. **General requirements.** Except as provided in part 9505.5040, second surgical opinions shall be required for medical assistance and general assistance medical care recipients for inpatient and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.0625, subdivisions 1 and 4. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second surgical opinion requirement. The department shall send each provider a copy of the published list or a revision of the published list.

Subp. 2. **Requirements prior to eligibility determination.** The requirements of parts 9505.5035 to 9505.5100 shall apply to individuals who have applied for MA or GAMC, but whose applications have not yet been approved or denied at the time the surgical procedure is performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

If the requirements of part 9505.5096 are met and the surgical procedure is medically appropriate as defined in part 9505.5005, subpart 12a, a second surgical opinion is not required in the circumstances set out in items A to F:

A. The surgical procedure is approved for reimbursement by Medicare.

B. The surgical procedure is a consequence of, or a customary and accepted practice as an incident to, a more major surgical procedure.

C. The procedure is an emergency. For an emergency, the physician shall submit substantiating documentation such as medical reports, progress notes, an admission history, or any other pertinent information necessary to substantiate the characterization of the surgical procedure as an emergency.

D. A visit to another physician to obtain a second opinion requires travel outside the local trade area.

E. The recipient has good cause for not obtaining a second opinion. Good cause refers to circumstances beyond the recipient's control. Examples of good cause include illness of the recipient, illness of a family member requiring the presence of the recipient, weather conditions that prohibit safe travel, or the unavailability of transportation.

F. The surgical procedure is performed before the individual's date of application for MA or GAMC, and retroactive eligibility was extended to cover the period of time during which the surgical procedure was performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5045 CRITERIA TO DETERMINE WHEN SECOND OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to E to determine which surgical procedures shall be subject to the second surgical opinion requirement.

A. Authoritative medical literature identifies the surgical procedure as being overutilized.

B. The surgical procedure is shown to be utilized to a greater degree within the Medicaid population than in the non-Medicaid population.

C. The utilization or cost of a surgical procedure falls within the top ten percent of all surgical procedures reimbursed under the MA and GAMC programs.

D. Alternative methods of treatment which are less intrusive are available.

E. The surgical procedure has at least a five percent rate of failure to obtain the requisite two physician's approvals, as determined by the Minnesota Medical Assistance Second Surgical Opinion Program or a similar second surgical opinion program.

STAT AUTH: MS s 256.991
HIST: 10 SR 842

9505.5050 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. **Second surgical opinion by medical review agent.** Except as provided in subpart 2, a second surgical opinion must be obtained from the medical review agent as specified in parts 9505.0520, subparts 6 and 8, and 9505.0540.

Subp. 2. **Second surgical opinion by a second physician.** If the department does not have a contract with the medical review agent to provide a second surgical opinion, a second surgical opinion must be obtained from a second physician.

Subp. 3. **Third surgical opinion.** If a second surgical opinion obtained under subpart 1 or 2 fails to substantiate the initial surgical opinion and the recipient still wants the surgery, a third surgical opinion shall be obtained from a third physician. No opinion beyond the third opinion shall be considered in meeting the requirements of this part. The cost of an opinion beyond the third opinion shall not be reimbursed under the medical assistance or general assistance medical care program.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Duties of physician offering to provide the surgical service.** If the recipient requires the opinion of a second physician under part 9505.5050, subpart 2, or if the medical review agent or the second physician determines that the surgical procedure requiring a second surgical opinion is medically inappropriate and the recipient needs a third opinion

under part 9505.5050, subpart 3, the physician offering to provide the surgical service shall provide to the recipient in need of the second or third surgical opinion the names of at least two other physicians who are qualified to render the surgical opinion, or the name of an appropriate medical referral resource service, and information about the consequences of failing to obtain a second or third opinion. The physician offering the surgical service shall ensure that the required second opinion or third opinion is obtained.

Subp. 2. **Qualifications of physician offering second or third opinions.** The physician offering the surgical service and the physician named to render a second or third opinion or the medical referral resource service shall have no direct shared financial interest or referral relationship resulting in a shared financial gain. The physician who gives a second or third opinion must be a provider and must meet the criteria on experience in treating and diagnosing the condition that requires a second or third surgical opinion as published in the State Register under part 9505.5035.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 10 SR 1688

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505.0475.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of a second or third surgical opinion under the medical assistance and general assistance medical care programs shall be permitted up to the allowable fee maximums as maintained by the department. When the physician who provides the second or third surgical opinion also performs the surgery, reimbursement for the surgery shall be denied.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion from the medical review agent or a second physician shall be obtained within 90 days of the date of the initial opinion. The surgical opinion from a third physician, if required, shall be obtained within 45 days of the date of the opinion of the medical review agent or the second physician. Approved surgery, if not performed within 180 days of the initial opinion, and if still requested by the recipient, shall require repetition of the second surgical opinion process as described in this part.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5075 PHYSICIAN RESPONSIBILITY.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure, on a form supplied by the department. The completed form shall contain all the information considered necessary by the commissioner to substantiate the second opinion, shall be personally signed by each physician providing an opinion, and shall be attached to a completed and signed prior authorization form. The completed form must be returned to the physician offering to provide the surgical service and must be retained and made available, for at least five years, by the physician to the department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Subpart 1. **Opinion of medical review agent.** Failure of the physician who offers to provide a surgical procedure requiring a second opinion to obtain a required surgical opinion from the medical review agent shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals.

Subp. 2. **Opinion of second or third physician.** Failure of a physician who offers to provide a surgical procedure requiring a second opinion to obtain the required surgical opinion from a second or third physician shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except the providers who rendered the second or third surgical opinion.

Subp. 3. **Submission of completed form to department.** If the second or third opinion by a physician does not substantiate the need for the surgical procedure and if the department does not have a contract with a medical review agent, then the physician offering to provide the surgical procedure shall submit the completed form to the department within 135 days of the date of the first opinion. Failure to comply with this subpart may result in termination of the provider's agreement with the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with parts 9505.5035 to 9505.5100 shall not seek payment from the recipient of the service and the recipient shall not be liable for payment for

the service for which reimbursement was denied.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

Subpart 1. **Medical review agent responsibility.** Except as provided in subpart 2, if the medical review agent agrees that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the information, and shall issue a hospital admission certification number if the procedure requires inpatient hospital admission.

If the third physician, consulted according to part 9505.5050, subpart 3, agrees with the physician offering to provide the surgical service that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the necessary information and forms, and shall issue a hospital certification number.

If the third physician agrees with the second opinion provided by the medical review agent that the requested surgical procedure is not medically appropriate, then the medical review agent shall deny an authorization number and a certification number and the department shall deny authorization of reimbursement for the requested surgical procedure. The medical review agent shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **If no medical review agent.** The department shall assign or deny an authorization number when the department does not have a contract with a medical review agent to determine the medical appropriateness of procedures requiring second surgical opinions.

If two of the three physicians agree that the requested surgical procedure is medically appropriate, the department shall certify that the requirements of this part are met and shall assign an authorization number within 30 working days of the department's receipt of the necessary information and forms.

If two of the three physicians agree that the requested surgical procedure is inappropriate, then the department shall deny authorization of reimbursement for the requested surgical procedure. The department shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5095 **Repealed, 13 SR 1688**